STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005106	A. BUILDING: _____ B. WING _____	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL	901 MACARTHUR BLVD MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State hospital complaint investigation. Complaint Number: IN00201908 Substantiated: no deficiencies related to allegations are cited. Date: 6/6/16 and 6/9/16 Facility Number: 005106 Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules. QA: cjl 06/10/16	S 000		